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ABSTRACT

This paper focuses on three issues: (1) gender seems to structure life chances so that women and men end up with quite different fates in later life; (2) maintaining a sense of adequate masculinity seems to remain very important to men until the end of life, and most women also seem to need to experience themselves as feminine, but are less threatened by gender-incongruent qualities; and (3) the gender system probably affects the quality and quantity of care available to people as health challenges are confronted later in life. More women survive to be old; unfortunately these additional years are often marked by poverty, ill health, and solitude. Older women are more likely to be widowed, and older men are more likely to be married. There is substantial evidence that the basic sense of gender identity is established in early childhood. Many men describe actions as good providers and protectors for their families as evidence of their masculinity. Many women define their femininity in terms of their actions as nurturing mothers and wives. Whatever gender-incongruent qualities are acknowledged are evaluated within the context of one's basic masculinity or femininity. Quantity and quality of care available to elders reflects the persistent gender structures of society's social arrangements and individuals' personal gender identity. (LLL)

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UNDERSTANDING GENDER DIVERSITY IN LATER LIFE

Presented at the Annual Scientific Meetings of the American Psychological Association, August 17, 1991, San Francisco; as part of the Symposium on Diversity in Later Life

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"Men and women, women and men. It will never work."

This quote, attributed to Erica Jong, reflects enduring doubts about our ability to construct satisfactory arrangements when we have always to work with creatures who are not just like us. Dealing with diversity is not a new challenge. The new APA Code of Ethics requires us to be sensitive, as psychologists, to the ways in which behavior may reflect gender, among other characteristics. What does this mean, particularly when we think about older adults?

I want to focus on three issues. First, gender seems to structure life chances so that women and men end up with quite different "fates" in later life. Second, maintaining a sense of adequate masculinity seems to remain very important to men until the end of life; most women also seems to need to experience themselves as feminine but they are less threatened by gender-incongruent qualities. And third, the gender system probably affects the quality and quantity of care available to us as we confront health challenges in later life.

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Gender and Later Life Fates

The broad parameters of how men and women fare in later life are fairly well known (Huyck, 1989a; Special Committee on Aging, 1989). Most dramatically, more women

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survive to be old; unfortunately, these additional years are often marked by poverty, ill health, and solitude. Older women are more likely to be widowed; older men are more likely to be married. While there are a few wealthy older women, many older women struggle for economic security. Women come to later life with fewer of the securities associated with participation in the labor force. Full-time employed women take an average of 11.5 years out of the labor force, usually for family care; men are out an average of one year, usually for illness (Older Women's League, 1988). Most older women, and even younger women, work at gender-segregated jobs, with lower pay and fewer fringe benefits; they are less likely to have health care coverage during their middle years, and less likely to have pensions during retirement (Older Women's League, 1990, 1991). Since 60% of the elderly women depend solely on Social Security for income, one of the substantial concerns is how to make this a more equitable system, to account for the different employment histories of women and men.

Men have higher mortality during their young adult years, largely a reflection of risk-taking behaviors and war, and from fatal diseases during their middle years (Verbrugge, 1988). Men also are more likely to commit suicide. Women have more chronic illnesses, and spend a greater proportion of their lives dealing with disabilities (Verbrugge, 1989). There are no differences in the rates of psychiatric illness, though women have higher rates of treatment for neuroses and functional psychoses and men are more likely to show antisocial personality disorders and alcohol and drug abuse (Cleary, 1987). Even when men and women have similar levels of emotional health, different factors may contribute to the sense of well-being or distress (Huyck, 1991a).

Unfortunately, treatment of health problems of older women is hampered in part by the inadequate knowledge base. Approximately 70% of the women's health research published between 1980 and 1985 focused on concerns of young adult women, leaving large voids in our knowledge about a wide range of other issues concerning women's health. Many key studies have not included women; only recently have Federal funding agencies required that researchers include both genders unless there are compelling reasons not to do so.

As psychologists, we must always be cautious about stereotyping or making assumptions about personal realities based general patterns of difference. While these broad patterns describe men and women in general, they do not describe any particular man or woman. We know that the patterns are also affected by race and ethnicity, by social class, by physical and mental abilities, and even by historical period. Thus, these observations are offered largely as reminders that we must also work for change at the macro level, to uncover the sources of differential life chances and to fashion such remedies as may be possible.

The Enduring Salience of Gender Identity

The second issue I wish to emphasize is much more psychological: the ways we experience ourselves as both distinctive (unlike others) and connected (like others). The term **gender** has come into use because it includes the ways in which the physiological facts of sex are given social and psychological meanings (Reinisch, Rosenblum, & Sanders, 1987). Gender identity includes our sense that we "belong" to one of the two major human groups--male or female, and that we possess the characteristics which are regarded as "appropriate" for that group. There is substantial evidence that the basic sense of gender identity is

established in early childhood, as part of the general cognitive process of categorizing (Deaux & Kites, 1987) and the emotional sensitivity to the ways in which others respond to us (Dinnerstein, 1977). Much of the earliest senses of who we are, and what differentiates us and those like us from Others occurs before we are rational. I believe that these earliest irrational assumptions about maleness and femaleness persist throughout life, even though they are modified by later, more reasoned appraisals.

I remind us of the evidence that survival in late life is linked to the capacity to retain a sense of continuity of self (Lieberman & Tobin, 1983). Persons living in nursing homes are more likely to survive if they can find ways of preserving their identity, even though some engage in some distortion of "current reality" in order to accomplish it. One aspect of identity involves gender-linked qualities. We must not forget that even old persons may anchor their sense of self partly in the fact that others respond to them as a man, or a woman--not just as a degendered, neutralized "person."

I think here of the woman struggling with cancer, who was deeply depressed when the surgeon removed her entire breast. The pain was amplified because the physicians assumed that -- because she was 83 and long widowed -- her breast was irrelevant. However, for this woman who had anchored her sense of feminine self on her ample breasts this was a major assault on her sense of self. I think of my father, after his prostate surgery when his physician told him that he would probably be impotent; my father's assessment was that he was "no longer a man."

While we have stereotypes about masculinity and femininity, I am most impressed with the ways in which adults fashion their own criteria by which they measure

themselves. I think of the middle-aged men and women in my study who responded to my questions about differences between women and men, and the ways in which they were masculine or feminine, and ways in which they were not so masculine or feminine (Huyck, Zucker, & Angelaccio, 1991). The men often acknowledged the stereotyped Marlboro man, or the hard-drinking, womanizing autonomous man; however, few of them thought that described them. Nearly all the men said they felt masculine. However, they identified several different ways of being masculine. Many described their actions as good providers and protectors for their families; as long as they took these responsibilities seriously, they felt masculine, even when they also recognized that they had not been able to do as much as they had wanted. Many men described general leadership qualities, within and outside the family, and used that as evidence of their masculinity. Some men described their masculinity in terms of physical characteristics (muscular, strong, penis), bravado, or heterosexual interest. What was impressive, however, is that they all could easily describe ways in which they defined themselves as masculine. They were grateful to persons who validated their sense of masculinity, and threatened by wives who challenged it (Huyck, 1991b).

The women in my study described themselves as feminine, using a wide array of evidence to support this sense of gendered self. My early impression, while interviewing, was that women felt very comfortable assuming many responsibilities and stances that they associated with men -- as long as they could also firmly anchor their sense of feminine self in something like curled hair, manicured nails, speaking softly, or even not wearing pants. Indeed, more systematic analyses showed that middle-aged women had a variety of ways in which to retain a sense of feminine identity. Many defined their femininity in terms of their

actions as nurturing mothers and wives, and many described sensitive nurturing beyond the family arena. Others focused more on dress and demeanor.

I believe that the creativity shown in defining oneself as "reasonably" gender-congruent indicates the salience of gender to adults throughout their life. However, there is substantial evidence, cross-culturally, that younger men feel "masculine" in part by repressing and repudiating aspects of themselves that are incongruent with their own sense of what is appropriately masculine. During midlife, these neglected aspects of the self re-emerge (Gutmann, 1987). Many writers--poets, novelists, essayists, and even psychologists -- have observed that most older men expand their ways of responding without feeling unmanly. They feel different than they did as younger men, but they retain a core sense of masculinity. The warrior may become the peacemaker, but both are regarded as versions of masculinity. Some men feel very threatened by the re-emergence of what they regard as their "feminine" self, and they may respond with rage, depression, illness or even suicide (Huyck, 1991c). Similarly, many midlife women are perceived socially as more openly managerial, confident, and assertive. Most older acknowledge such qualities in themselves, and expand their basic sense of femininity to include these characteristics. Some women are very frightened by their own aggressive or even assertive potentials, and fear that they will destroy all they have worked to preserve.

The key point is that whatever gender-incongruent qualities are acknowledged are evaluated within the context of one's basic masculinity or femininity. The retired man who said that he was not so masculine because he really enjoyed growing things in his garden was evaluating that activity in terms of a sense of what was acceptably masculine, given his

history. It is not particularly helpful for us to assume that gardening should be gender-neutral; for this man, it is not. He was clear that it was OK -- not threatening to him --to grow vegetables because he could still feel like the provider, but it was a little threatening to admit his joy in growing flowers, because that seemed so feminine to him. If we are to understand that man, and other adults, we must enter their world and find out how they have gendered it. Expansion of one's gender style to include qualities associated with the Other seems most likely and comfortable when one retains a secure sense of congruent gender identity.

The Cultures of Caring

The final issue I want to raise builds upon the first two. I believe that the quantity and quality of care available to elders reflects the persistent gender structures of our social arrangements and our personal gender identity.

It is no news that women take care -- of small children, of ill or incapacitated family members, of immobilized adult children, of frail parents, and of dying husbands (Sommers & Shields, 1987). Hands on, diaper-changing, sleepless-nights kinds of care. The care of worry, delicately monitoring the balances of assistance and autonomy which will preserve as much independence as possible for both partners. The relationship work, where women take seriously the complex strands of obligation, passion, hope, and identification that bind people together. These kinds of caring are regarded as "women's work."

There are other kinds of caring. Sons and fathers are more apt to arrange for someone else (a woman) to provide direct care; they will pay for it. Physicians provide expert care, and the highest status and compensation is granted to doctors who do the most

complex, "high tech" procedures. Mastery of medications and machines defines modern medical care. However, it is becoming increasingly evident that much of the health care we need in later life involves sensitivity to the psychosocial aspects of health and illness. The recent report on how to promote healthy people by 2000 emphasizes preventive care rather than high-tech medical interventions (U.S. Dept of Health and Human Services, Public Health Service, 1991). It is also fairly obvious that we are confronting a major social crisis because it is difficult to attract physicians into geriatric care, even though the needs are clear (Vivell, Solomon, & Beck, 1987). I believe that one of the difficulties in attracting persons into geriatrics is that caring for older patients involves too many women and too much interpersonal care -- women's work.

These issues have become clearer to me this summer, as I have worked as a fellow in the Technical Assistance Program of the Gerontological Society. My task is to evaluate a very innovative program for educating medical residents taking a geriatric rotation. The third year residents from Evanston Hospital spend one-half day a week at the North Shore Senior Center, with a senior attending physician and one or more social workers from the Center. The program was designed to give the residents more experience with "ambulatory elders", that is, people not in hospitals. Most older people are not in the hospital, of course, but physicians can go through much of their training without getting much exposure to the ways in which older folks manage their lives in spite of various health challenges. As part of their NSSC experience, the physicians attend support groups for persons with Parkinsons or hearing impairments, visit the dementia day care program, accompany the social worker on a home visit, or make themselves available to the seniors at

the Center for consultation on a variety of health issues. The focus has been on helping them understand the psychosocial aspects of health, to appreciate the concerns of family caregivers, to develop appropriate communication skills for elders with hearing or cognitive impairments, and to become aware of the kinds of community support services available to supplement their health care planning.

As part of my evaluation, I have been interviewing the ten resident physicians, the nine mentor physicians, and the ten or so social workers who have been involved in this program. While this is a small number and I have not yet analyzed the data systematically, two themes relevant to this symposium seem to be emerging.

First, virtually all of the resident and mentor physicians describe caring for older patients as involving more time and more sensitivity than working with younger patients. Older patients have complex medical problems, compounded by long histories and often-complex life situations. These doctors recognize that their therapeutic impact may hinge on their ability to negotiate family relationships or combat hopelessness as much as their ability to identify the correct drug or order the right procedure.

Secondly, some of the physicians are more comfortable with this reality than others. Generally, the women residents seem more at ease with these aspects of their practice; they are identified as particularly skillful by their mentors and by the social workers, and the women often describe the psychosocial aspects of their medical care as a special pleasure in working with the elderly. In contrast, some of the young men seems to find these aspects alien, or a source of frustration. The mentor physicians, all men, discuss the issue obliquely, referring to the difficulties of dealing with older patients because of the

great complexity of their situations. The senior physicians also mention the relatively low compensation for geriatric practice. Medicare reimbursement reflects the wider social biases: compensation is highest for those who perform procedures, like surgery, which involve little interaction with the patient's life, and much less for health care professionals who tend to the psychosocial aspects--women's work.

More women are becoming physicians, and they may revitalize medicine in ways which will be good for older persons. They may find it more compatible to do the kinds of medical care which promote vitality, by combining medical knowledge with sensitivities to the behaviors which promote wellness and compliance with treatment plans. However, at the present time we cannot count on excellent, appropriate care in later life.

I have raised three issues about the ways in which gender contributes to the diversity of experience in later years. I have suggested that life chances are shaped broadly along lines of gender; that retaining a sense of congruent gender identity remains important to the end of life; and that gender distinction patterns may contribute to the inadequate health care available in later life. The reasons for these differences are not entirely clear, though several models have been proposed (Gutmann, 1987; Hess & Ferrea, 1987; Huyck, 1989a, 1989b; Orey & Warner, 1990). We need not debate these models here, but we must recognize that our implicit models of causation direct our change efforts. I personally do not believe we will ever make men and women interchangeable. We are stuck with each other, and we must plan for the realities of women and men. However, we can work to modify the negative consequences of difference.

Men and women, women and men: let's make it work.

REFERENCES

Cleary, P.D. (1987). Gender differences in stress-related disorders. In R.C. Barnett, L. Bierer & G.K. Baruch (Eds.), Gender and stress (pp 39-72). New York: Free Press.

Deaux, K. & Kites, M.E. (1987). Thinking about gender. In B.B. Hess & M.M. Feree (Eds.), Analyzing gender (pp 92-117). Beverly Hills, CA: Sage.

Dinnerstein, D. (1977). The mermaid and the minotaur: Sexual arrangements and human malaise. New York: Harper.

Gutmann, D.L. (1987). Reclaimed powers: Toward a new psychology of men and women in later life. New York: Basic Books.

Hess, B.B. & Ferrea, M.M. (Eds.)(1987). Analyzing gender: A handbook of social science research. Beverly Hills, CA: Sage.

Huyck, M.H. (1989a). Gender differences in aging. In J. Birren & K.W. Schaie (Eds.), Handbook of the psychology of aging (3 Ed) (pp 124-132). New York: Van Nostrand Reinhold.

Huyck, M.H. (1989b). Models of midlife. In R. Kalish (Ed.), Midlife loss: Coping strategies (pp 10-34). Newbury Park, CA: Sage.

Huyck, M.H. (1991a). Predicates of personal control among midlife and older men and women in middle America. International Journal of Aging and Human Development.

Huyck, M.H. (1991b). Thirtysomething years of marriage: Understanding husbands and wives in enduring relationships. In Gender and the Family, Proceedings of the International Conference on Gender and the Family, Brigham Young University, Provo, Utah.

Huyck, M.H. (1991c). Gender-linked self-attributions and mental health during the middle years. Journal of Aging Studies, 5(1), 111-123.

Huyck, M.H., Zucker, P., & Angelaccio, C. (1991). Gender across generations. In Gender and the Family, Proceedings of the International Conference on Gender and the Family, Brigham Young University, Provo, Utah.

Lieberman, M. & Tobin, S. (1983). The experience of old age: Stress, coping and survival. New York: Basic Books.

Older Women's League (1988). The Road to Poverty: A Report on the Economic Status of Midlife and Older Women in America. OWL, 730 Eleventh Street N.W., Suite 300, Washington, D.C. 2001.

Older Women's League (1990). Heading for Hardship: Retirement Income for American Women in the Next Century. OWL, 730 Eleventh Street N.W., Suite 300, Washington, D.C. 2001.

Older Women's League (1991). Paying for Prejudice: A Report on Midlife and Older Women in America's Labor Force. OWL, 730 Eleventh Street N.W., Suite 300, Washington, D.C. 2001.

Orey, M.G. & Warner, H.R. (Eds.) (1990). Gender, health, and longevity: Multidisciplinary perspectives. N.Y.: Springer.

Reinish, J.M., Rosenblum, L.A., & Sanders, S.A. (Eds.) (1987). Masculinity/ femininity: Basic perspectives. New York: Oxford University Press.

Sommers, T., Shields, L. and the OWL Task Force on Caregiving (1987). Women take care: Consequences of caregiving in today's society. Triad Publishing. [Available from OWL, 730 Eleventh Street, N.W., Suite 300, Washington, D.C. 2001]

Special Committee on Aging, United States Senate (1989). Aging America: Trends and Projections. U.S. Govt. Printing Office, Serial No. 101-E.

U.S. Dept of Health and Human Services, Public Health Services (1991). Healthy People 2000: National Health Promotion and Disease Prevention Objectives. DHHS Publication No. (PHS) 91-50212.

Verbrugge, L. (1988). Unveiling higher morbidity for men. In M. Riley (Ed.), Social Structures and Human Lives (pp 138-160). Beverly Hills, CA: Sage.

Verbrugge, L. (1989). Gender, aging and health. In K.S. Markedes (Ed.), Aging and Health: Perspectives on Gender, Race, Ethnicity, and Class (pp 23-78). Newbury Park, CA: Sage.

Vivell, S., Solomon, D.H., & Beck, J.C. (1987). Medical education responds to the 20th century's success story. Journal of American Geriatrics Society, 35:1107-1115.